SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS (DDSN)
Harassment Complaint Form

Name of the Complainant:_____

Department:_____

Phone Number *(include area code)*:_____ E-mail:_____

Today's Date:_____

Name of the Accused:_____

Department:_____

Relationship of the Accused to the Complainant *(manager/supervisor, co-worker, contractor, volunteer, etc.)*:

_____

Phone Number *(include area code):*_____ E-mail:_____

Date of Incident: *(If more than one event, please report each event on a separate form.)*

Where did the specific event occur?

Please explain the events that occurred.

How did you react to the situation? Did you take any action to stop perceived inappropriate behavior?

Describe the harm you have suffered as a result of the event.
Were there any witnesses to this specific event? *(If yes, please provide their names)*

Is there any physical evidence that supports your complaint? *(If so, please describe or attach copy of evidence)*

What is your desired outcome of the investigation?

The information provided in this complaint is true and correct to the best of my knowledge. I am willing to cooperate fully in the investigation of my complaint and provide whatever evidence DDSN deems relevant.

_____ Date:_____

Signature